State of Indiana Office of Medicaid Policy and Planning
Quality Strategy, 2007-2008

SECTION I. INTRODUCTION

Quality Strategy Overview

The *overarching mission* of the Indiana Office of Medicaid Planning and Policy (OMPP) is to improve the quality and quantity of Hoosier lives in an outcome and value driven health care system. The Indiana OMPP will achieve this mission through a strategy that involves data driven decision making, implementation of evidence-based practices, fiscal responsibility, and active engagement with providers, members, health plans, and state and local governments.

The Indiana Office of Medicaid Policy and Planning supports the Institute of Medicine's 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*. This comprehensive report laid the framework for how the health care delivery system can be designed to innovate and improve health care in the United States. As the Indiana OMPP seeks to improve the delivery of health care to increase the quality and quantity of life for persons enrolled in Medicaid programs, we seek to implement many of the tenets recommended by the Institute of Medicine. As Indiana moves forward to 2008 and beyond, an administrative restructuring of Indiana OMPP will allow the agency to closely work with consumers, stakeholders, health care organizations, professional groups, and others to develop strategic goals and action plans to achieve substantial improvement in quality. We believe that healthcare should be safe, effective, patient-centered, timely, efficient, and equitable. In developing a healthcare strategy for the state of Indiana, we recognize that quality encompasses both outcomes and value. In order to ensure that the quality and quantity of life is maximized for our citizens, the responsible delivery of healthcare services must be data driven and fiscally sound. Our future quality strategies will outline initiatives to reduce illness, and to pursue the improvement of health and functioning of our citizens. We will undertake data driven and evidence-based decision making, engage in transparency of reporting to encourage informed decision making by patients, families, and stakeholders, and encourage the implementation of best practices.

The Quality Strategy presented herein applies to Hoosier Healthwise, Indiana's Medicaid risk-based managed care (RBMC) program. In the future, Indiana will expand the scope of the Quality Strategy to include other Medicaid-funded programs, such as the Healthy Indiana Program developed for low-income uninsured adults, and the Care Select program, a program for the age, blind, and disabled. The foundation for these future quality strategies will rely upon the identification of need for improvement based on data, will prioritize initiatives based on prevalence, cost, morbidity, and the ability to implement meaningful interventions.

The current Indiana Quality Strategy is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess

and continually improve the quality of health care services to participants in managed care. The Quality Strategy provides a framework to communicate the State's vision, objectives and monitoring strategies addressing issues of health care cost, quality and timely access in Medicaid managed care. It encompasses an interdisciplinary collaborative approach through partnerships with enrollees, stakeholders, governmental departments and divisions, providers, contractors, managed care organizations (MCOs), managed behavioral health organizations (MBHOs), academics and community groups.

The Hoosier Healthwise Program

The Hoosier Healthwise Program, administered through the Office of Medicaid Policy and Planning (OMPP), provides health care services to Indiana's children, low-income families and pregnant women. Individuals who enroll in Hoosier Healthwise are eligible for either Medicaid benefits or benefits through the Children's Health Insurance Program (CHIP).

The State contracts with MCOs to provide services to Hoosier Healthwise enrollees. Through Hoosier Healthwise, eligible individuals have a medical home, care coordination and a committed provider network throughout the State. The overall goals of the Hoosier Healthwise program are to:

- Ensure access to primary and preventive care
- Improve access to all necessary health care services
- Encourage quality, continuity and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Indiana believes that managed care provides a cost-effective, high quality service delivery model that includes continuity and care coordination between primary, specialty and inpatient services. The concept of a medical home, including providing appropriate services at the appropriate time in the appropriate setting is fundamental to managed care.

History of Hoosier Healthwise

Indiana established the Hoosier Healthwise program in 1994 under the administration of OMPP. The State first introduced a Primary Care Case Management (PCCM) delivery system called *Prime*Step and later implemented a Risk-Based Managed Care (RBMC) delivery system. The RBMC delivery system is made up of MCOs, which are state-contracted Health Maintenance Organizations (HMOs). OMPP phased in the Hoosier Healthwise program and by July 1997, the Hoosier Healthwise program was statewide. The RBMC and PCCM delivery systems operated simultaneously until the PCCM program was phased out in 2005.

The history of the Hoosier Healthwise program includes the following key dates:

- **1994:** Hoosier Healthwise begins with the PCCM delivery system
- **1996:** Hoosier Healthwise RBMC delivery system enrollment begins
- **1997-1999:** Managed Care for Persons with Disabilities (later changed to Hoosier Healthwise for Persons with Disabilities and Chronic Illnesses) pilot program in Marion County
- **1998:** Hoosier Healthwise Program expands to include CHIP Phase I (expanded Medicaid eligibility up to 150 percent of Federal poverty level)
- **2000:** Hoosier Healthwise Program expands to include CHIP Phase II (expanded Medicaid eligibility up to 200 percent of Federal poverty level)
- **2002-2004:** Transitions to Mandatory RBMC (Allen, Delaware, Elkhart, Lake, Grant, Howard, Johnson, LaPorte, Madison, Marion, Morgan, Porter and St. Joseph Counties)
- **2005:** Mandatory RBMC expands to all Indiana counties; PCCM is phased out
- **2007:** Behavioral Health services are carved-in to Hoosier Healthwise; option to choose a primary medical provider (PMP) is changed, members now first choose a health plan and then a PMP within that plan
- **2007:** OMPP anticipates implementing the first phase of the Care Management program for the disabled population in Marion County

Risk-Based Managed Care

Starting in 2002, the State began to expand mandatory RBMC in several new counties. The State transitioned PCCM members in these counties into MCOs. In 2005, OMPP implemented mandatory risk-based managed care enrollment across all Indiana counties. Throughout the year, the state transitioned all remaining PCCM members into MCOs.

Beginning with new MCO contracts in 2007, OMPP introduced significant changes to the Hoosier Healthwise program design. Hoosier Healthwise historically required primary medical providers (PMPs) to contract with only one Hoosier Healthwise MCO. Members picked a PMP and were then assigned to the MCO to which their PMP belonged. In the new program design, PMPs may contract with multiple health plans, so Hoosier Healthwise members must choose an MCO and then choose a PMP from the MCO's network.

This modification provides greater freedom of choice for members, and helps assure better access and availability of providers across the State.

Behavioral Health Carve-In

Also beginning in 2007, the State included or "carved-in" behavioral health to managed care for the first time. Prior to January 1, 2007, OMPP paid for most behavioral health services outside of Hoosier Healthwise. Authorizing and reimbursing for behavioral health services, which include mental health, chemical dependency and substance abuse

services, are now the MCO's responsibility. Each of the current MCOs has contracted with a MBHO to provide behavioral health services to Hoosier Healthwise members.

The State's goals for carving-in behavioral health to managed care are to:

- Provide care that addresses the needs of Hoosier Healthwise members in a more holistic manner
- Increase communication between the PMP, the MCO and the behavioral health care provider
- Better manage utilization of behavioral health care services

In setting performance standards for the behavioral health program, OMPP recognized that integrating behavioral and physical health services within the MCO will provide a seamless delivery system and better continuity of care, and will promote the concept of ownership of the member's total health care. Therefore, OMPP contractually required each of the Managed Behavioral Health Organizations to employ Behavioral Health Care Managers who communicate with and facilitate linkages among PMPs, specialists and behavioral health providers, especially for Hoosier Healthwise members who have experienced an inpatient behavioral health hospitalization or are at risk for inpatient hospitalization. OMPP is in the process of developing metrics that will help them monitor the effectiveness of the MCOs' efforts to integrate behavioral and physical health.

History of Hoosier Healthwise Quality Improvement Achievements

Since Hoosier Healthwise began tracking quality indicators, the program has made substantial gains in measuring and improving performance on measures related to quality. One example of a Hoosier Healthwise successful initiative follows:

Best Clinical and Administrative Practices (BCAP)

Indiana participated in a Center for Health Care Strategies (CHCS)-sponsored asthma collaborative with California and New York State. The states agreed to collect and share the results from a common set of measures and report on the progress of the initiative beyond their individual pilot projects.

The common measures include one asthma measure collected as part of NCQA's Healthcare Effectiveness Data and Information Set (HEDIS)[1] data set as well as three new measures developed by the workgroups. These measures provide a common metric for MCOs in BCAP workgroups to track progress at the MCO level and to document improvement in the total population with asthma, not just the smaller number of members touched by each MCO's pilot interventions.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The MCOs collected data for the following common measures:

- Identification of members with asthma (by age and race/ethnicity)
- Asthma-related inpatient admissions and days (for total membership and those with asthma)
- Asthma-related emergency department visits (for total membership and those with asthma)
- Use of Appropriate Medications for People with Asthma (HEDIS® measure)

The MCOs collected data annually for at least three years.[2] The MCOs collected and reported the first baseline (pre-intervention) data in 2002. The MCOs will collect and report the last data (post-intervention) for calendar year 2007.

Over the course of the BCAP program, the Hoosier Healthwise MCOs achieved notable success in improving rates for two of the four BCAP measures. The MCOs demonstrated a statistically significant decrease in the number of annual asthma-related hospital days for members with persistent asthma from measurement year 2004 to measurement year 2005.

Additionally, the Hoosier Healthwise MCOs performed exceptionally well on the HEDIS asthma measure *Use of Appropriate Medications for People with Asthma*, which was also one of the BCAP measures. Overall, there was statistically significant improvement for this HEDIS measure from measurement year 2004 to measurement year 2005. For HEDIS 2006 (measurement year 2005), all MCOs reported rates above the 90th NCQA percentile. It appears OMPP's emphasis on asthma and the health plans' involvement in the BCAP project helped drive improvement for this rate.

Quality Strategy Evolution

The Hoosier Healthwise Quality Strategy Committee reports to the OMPP Medicaid Director and Executive Team. The role of the Committee is to assist in developing and monitoring the Quality Strategy, and to advise and make recommendations to the OMPP Medicaid Director and Executive Team. The OMPP Director of Quality and Outcomes, who reports directly to the OMPP Medicaid Director, chairs the Committee. Currently, the members of the Quality Improvement Committee include representatives from:

- Office of Medicaid Policy and Planning (OMPP)
- Department of Mental Health (DMHA)
- Indiana State Department of Health (ISDH)

[2] Not all of the MCOs were active in the Hoosier Healthwise program for the entire three-year period.

- Providers (pediatrician, adult health, behavioral health)
- MCO Quality Managers
- Advocacy groups
- Consumers
- Academia
- Each of the 2007-2008 OMPP quality initiative workgroups, e.g., Neonatal Outcomes, Preventive Care and Behavioral Health.

The Quality Strategy Committee's responsibilities include development and oversight of quality plans and quality improvement activities. The Committee is the central forum for communication and collaboration for oversight plans and activities and provides the opportunity to develop systematic and integrated approaches. The Committee reviews and uses available MCO monitoring data to analyze and identify trends, discuss findings and identify and prioritize opportunities for strategically integrating QI activities into overall monitoring of the MCOs. Within this process, opportunities are sought to develop collaborative quality activities that span across Hoosier Healthwise MCOs.

The Committee also meets regularly to develop, review and update the Quality Strategy. In developing quality priorities and activities, the Quality Strategy Committee reviews historical MCO performance data, current MCO quality initiatives and input from government agencies, providers, MCOs, MBHOs, consumers and advocates. The appendices to this document provide a sample of the types of data the Committee reviews. The Committee, under the direction of OMPP, also solicits public and member input as described below.

Public Input
The State will formally distribute the Quality Strategy to stakeholders, will discuss the Strategy at public meetings and will post the Strategy on the Family and Social Services Administration (FSSA) website for general public comment. Any significant change in the Strategy will result in the State seeking stakeholder input for revising the Quality Strategy. A significant change is one that results in a statewide change in policy or procedure that affects member access to services or providers' procedures. Representatives of OMPP, in collaboration with the Quality Strategy Committee, will review the Quality Strategy at least quarterly to identify if any significant changes have occurred.

Participant Input
The State also assures the involvement of Hoosier Healthwise members in the development and monitoring of the Quality Strategy. All quality meetings are public meetings and publicly posted. OMPP will welcome the participation of members at these meetings. In addition, as appropriate, OMPP will invite members to more actively participate in workgroups more specifically focused on a particular topic. In addition,

the State will discuss the Strategy at public meetings, and will post the Strategy on the FSSA website for general public comment.

Mission of the Quality Strategy Committee
The Mission of the Hoosier Healthwise Quality Strategy Committee is to provide leadership in fostering collaboration within the Hoosier Healthwise health system among stakeholders, including enrollees, in order to improve the desired health outcomes and quality of health for members, and to maximize value for all system enrollees.

History of the QIC/Clinical Studies Committees
Previously, OMPP's quality committees were the Quality Improvement Committee (QIC) and the Clinical Studies Committee. OMPP required the MCOs to participate in these committees. The QIC provides oversight for the appropriateness and quality of the care and services provided to enrollees in the Hoosier Healthwise Program through establishing standards and guidelines for provision of care and services and by reviewing monitoring and evaluation reports.

In the past, the QIC met monthly and provided a forum for MCOs to report on MCO quality improvement activities to OMPP. The Clinical Studies Committee, which eventually merged with the QIC, reviewed and discussed MCO quality data. For several years, OMPP aggregated baseline data reported by the MCOs through HEDIS, consumer surveys including Consumer Assessment of Healthcare Providers and Systems (CAHPS) and provider surveys. The MCOs used the results of these three data collection activities, and other internal initiatives, to direct MCO-specific quality activities.

In anticipation of the new Hoosier Healthwise program scheduled to be implemented on January 1, 2007, and in recognition of the fact that MCOs had been building systems and collecting baseline data for a number of years and were currently operating with experienced or "mature" delivery systems, OMPP decided to revisit the structure and function of the QIC in an effort to make the quality improvement process more robust and meaningful. This decision represents an exciting opportunity for OMPP, in partnership with the MCOs and other stakeholders, to move into the next generation of quality improvement, and to begin to use data and experience to develop and implement meaningful quality improvement initiatives on a statewide basis.

In the third quarter of 2006, OMPP discontinued formal QIC meetings and charged a small planning committee of OMPP, provider and MCO representatives to meet regularly to prepare the new QIC for 2007. During this planning time, the MCOs continued to work on their own internal quality improvement activities while contributing to this OMPP planning process. In fact, many of the performance measures identified by the current Quality Strategy Committee as a focus of the 2007-2008 Quality

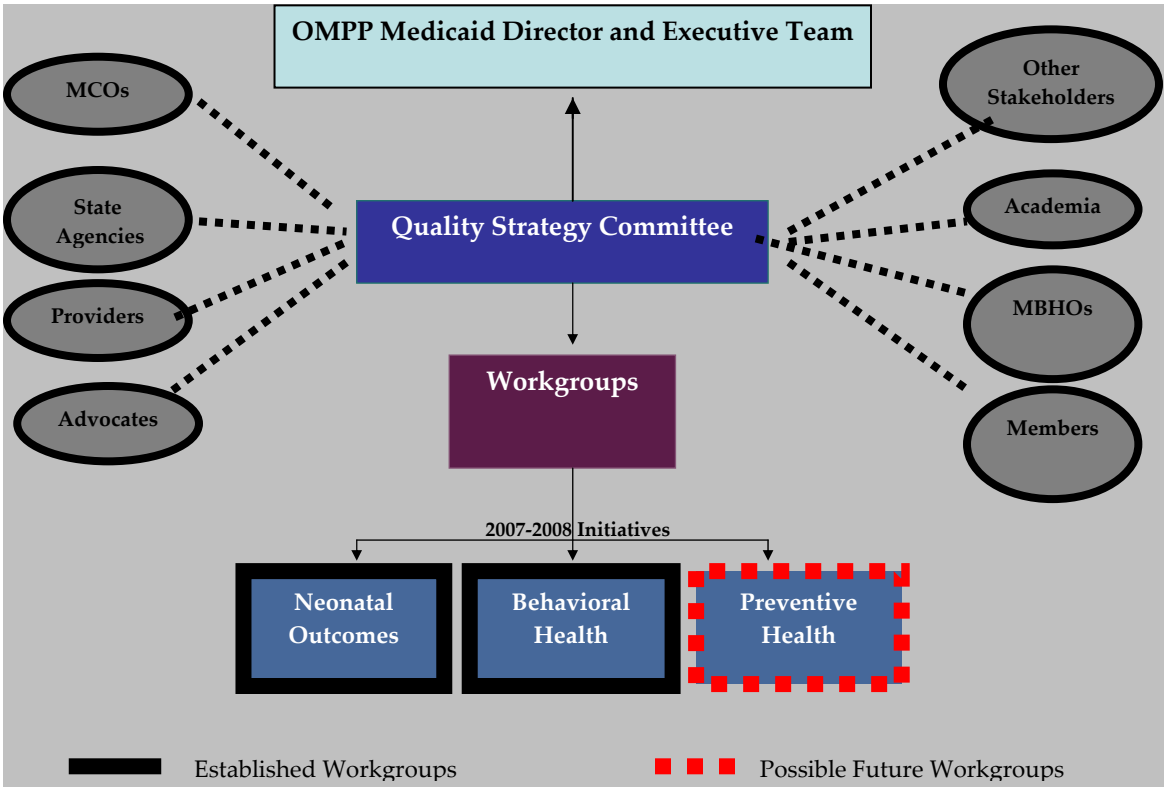
Strategy were identified and prioritized by the MCOs as a result of their ongoing continuous quality improvement efforts. The planning committee proposed the QIC structure described below, and the QIC agreed to adopt this structure at its formal QIC meeting on November 15, 2006.

Structure and Function of the Current Quality Strategy Committee

The Quality Strategy Committee acts as the advisory body of the Hoosier Healthwise quality program. This committee advises both the Director of Indiana OMPP and the Director of Indiana OMPP's risk-based managed care programs. Contributors to the development of the new quality improvement structure liken the Quality Strategy Committee to a "Quality Board of Directors." The Quality Strategy Committee is supported by workgroups that make recommendations on specific topics and report up to the Quality Strategy Committee. See Figure 1 for a visual representation of the Quality Strategy Committee structure.

Currently, State agency staff and representatives of academia, the MCOs, the MBHOs and the provider community serve as members of the various ad hoc workgroups. It is OMPP's intent to further involve other stakeholders, including Hoosier Healthwise enrollees and advocates, as members and guests at various other meetings of the Quality Strategy Committee and workgroups, as appropriate.

Figure 1: Structure of the Quality Strategy Committee



The Quality Strategy Committee meets quarterly and conducts a public meeting following each of its quarterly meetings to report on quality initiatives and to solicit input. The OMPP Director of Quality and Outcomes, who reports directly to the Indiana Medicaid Director, chairs this committee, and ultimately assumes leadership of Indiana's Quality Strategy for the Indiana Health Coverage Program (IHCP), of which Hoosier Healthwise is a part. Representatives of the MCOs, including CEOs and Medical Directors, MBHOs, state agencies and the provider community are invited to Quality Strategy Committee public meetings, although all Quality Strategy Committee and workgroup meetings are public meetings.

There are currently several smaller, topic-specific workgroups that meet regularly on specific quality issues: the Behavioral Health Workgroup and the Neonatal Outcomes Workgroup. These workgroups include representatives from MCOs and MBHOs, state agencies and providers (including primary care physicians, community mental health centers and other behavioral health providers). With OMPP approval, the Quality Strategy Committee may develop additional workgroups as necessary; for example, OMPP is currently planning to initiate another workgroup that will focus on preventive

services, and is discussing a strategy for including representatives of the new Care Management program that focuses on the quality of care and services for the aged, blind and disabled population.

The Behavioral Health Workgroup addresses issues such as how to standardize and streamline operational processes, provider clinical data sharing, and communication and integration of care between primary care and behavioral health providers.

The Neonatal Outcomes Workgroup is currently developing a study and a series of Quality Improvement Activities (QIAs) to reduce smoking rates and increase rates of prenatal care for pregnant women in the Hoosier Healthwise program, in an effort to improve neonatal outcomes. See page 12 of this report for a more detailed description of this study.

Additional Medicaid and Other State Program Committees
There are additional Medicaid and other State committees that may interact with the Quality Strategy Committee. These committees include:

- Medical Management Advisory Committee (MMAC)
- Medical Policy Committee
- Managed Care Policy/Operations Committee
- Managed Care Technical Committee
- Mental Health Quality Advisory Committee
- Drug Utilization Review Board

The current QI structure includes some linkages to these additional committees to obtain input on cross-agency issues that affect quality; representatives from several of these groups sit on the Quality Strategy Committee and on one or both of the workgroups. For example, the Quality Strategy Committee receives regular feedback from the MMAC, an advisory group of physicians representing primary care, pediatrics, geriatrics, psychiatry and other medical specialties, regarding the Quality Strategy and any quality improvement initiatives. It is OMPP's intent to establish formal communication linkages with each of these committees going forward.

The Quality Strategy Committee presented goals and objectives to several other internal state agencies and committees to obtain feedback on the Quality Strategy. On an ad-hoc basis, the Quality Strategy Committee will identify opportunities to present issues to these committees.

Hoosier Healthwise Quality Goal and Objectives

Based on review of prevalence and morbidity data, the Quality Strategy Committee recommended the Hoosier Healthwise program adopt three over-arching quality goals:

1) To improve neonatal outcomes
2) To improve behavioral health care service delivery
3) To improve prevention and wellness

MCO Collaboration
Achievement in these areas will require collaboration among MCOs as well as other stakeholders, including community resources, schools, OMPP and other state agencies that have initiatives focused in similar areas. Initiatives will include member and provider education, screening and identification.

Objectives
The following represents the Quality Strategy Committee's recommendations to OMPP as to how OMPP should focus resources toward monitoring, measuring and improving quality for newborns within the Hoosier Healthwise program. Indiana OMPP recognizes that adverse neonatal outcomes impair quality of life for children, result in high health care utilization, and have downstream societal effects on role and social functioning. Our overall neonatal quality objectives include:

Objective 1: *Increase the number of women entering prenatal care in their first trimester or within 42 days after enrollment in an MCO by 5 percent over three years.*

Objective 2: *Decrease the percentage of low birth weight babies by two percent and very low birth weight babies by 5 percent over three years.*

Objective 3: *Decrease pre-term births by 5 percent over three years.*

We developed a strategy based on best evidence for a program to reduce neonatal morbidity. It is well-established that maternal smoking during pregnancy results in adverse outcomes such as low birth weight, very low birth weight and pre-term birth. Indiana has a relatively high rate of maternal smoking during pregnancy compared to the national average. In 2004, 18.1 percent of Indiana mothers reported smoking during pregnancy compared to 10.2 percent of mothers nationwide.[3]

[3] Indiana State Department of Health, "Smoking During Pregnancy in Indiana, 1999-2004," (October 2006).

The Quality Strategy Committee recommends reducing maternal smoking rates to positively affect birth outcomes among Medicaid members. The Committee specifically recommended the following initiatives to achieve the goal of reducing adverse neonatal outcomes.

Initiative 1: *Establish a Hoosier Healthwise baseline for maternal smoking during pregnancy, prenatal care in the first trimester (or within 42 days of enrollment in an MCO), low birthweight, very low birthweight and preterm births.*

Initiative 2: *Decrease the rate of women who smoke during pregnancy by 5 percent over three years.*

The Quality Strategy Committee has met to develop the methodology for collecting and aggregating data to establish a baseline for the Quality Strategy objectives. The Committee will continue to meet to determine the best way to progress towards meeting the goals and objectives outlined in this section. The Committee discussed potential quality improvement activities related to improving neonatal outcomes and developed a workplan for implementing the quality initiatives necessary for meeting the Quality Strategy goals and objectives.

OMPP values an inter-disciplinary, multi-stakeholder approach to addressing quality. Many of the areas targeted by the Quality Strategy will require collaboration among providers, MCOs, community resources and multiple State agencies. As part of the workplan, the Quality Strategy Committee will investigate how to create partnerships and linkages between Hoosier Healthwise and other existing programs and resources that serve the Hoosier Healthwise population.

SECTION II. ASSESSMENT

Quality and Appropriateness of Care

This Section addresses various CMS requirements related to ongoing assessment of progress in meeting the goals described in Section I. This Section includes many of OMPP's contract requirements, including the regular performance reporting requirements. OMPP and the Quality Improvement Committee use data reported by the MCOs and MBHOs, on-site monitoring and other monitoring mechanisms to assess whether these organizations are providing appropriate, high quality care to Hoosier Healthwise members and meeting the goals and objectives described in the Quality Strategy.

Procedures for Race, Ethnicity and Primary Language Data Collection and Communication
Data regarding race and primary language are currently available in the Indiana AIM system. Case workers processing enrollments for Medicaid members solicit and enter this data at the time of the member's enrollment. The State does not currently capture ethnicity data due to system limitations but is investigating collecting this data in the future.

Although OMPP does not currently provide data regarding race directly to the MCOs, OMPP is pursuing ways to communicate this data to the MCOs. Particularly because the community mental health centers and other behavioral health providers have identified that race and ethnicity are often factors determining utilization of behavioral health services, it is critical for the MCOs and MBHOs to have access to this data so that they can direct outreach and education efforts to those members who may not seek appropriate services due to social stigma or demographic issues. In addition, the MCOs would use race and ethnicity data to understand how race and ethnicity issues may affect outcomes.

The MCO contracts include language requirements compliant with Federal regulations. The MCO must make written information available in English and Spanish and other prevalent non-English languages identified by OMPP, upon the member's request. In addition, the MCO must identify additional languages that are prevalent among the MCO's membership and provide oral translation services to members.

The State's fiscal intermediary, EDS, includes data regarding primary language spoken in the enrollment file it sends to the MCOs twice monthly. Language designations are English and Spanish. These categories are based on Federal census data for the State of Indiana. The majority of non-English speaking members speak Spanish (three percent); other languages are represented as very small percentages. Communicating primary language data to the MCOs and MBHOs electronically via the twice-monthly enrollment

file is both efficient and timely, and OMPP intends to continue this process. The MCOs use primary language data to support member services, develop member materials, provide interpretive services, identify staff training needs and determine the need for and availability of providers with non-English speaking capacity.

The enrollment broker provides oral translation services to all potential enrollees and enrollees, regardless of language spoken, via the AT&T Language Line with translations in 190 languages.

The MCO must maintain a statewide toll-free telephone helpline for members with questions, concerns or complaints. The MCO must staff the member services helpline to provide sufficient "live voice" access to its members during (at a minimum) a ten-hour business day, Monday through Friday. The member services helpline must offer language translation services for members whose primary language is not English and must offer telephone-automated messaging in English and Spanish. A member services messaging option must be available after business hours in English and Spanish and member services staff must respond to all member messages by the end of the next business day.

The MCO must also provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members.

Identification of Members with Special Health Care Needs
The MCOs must have plans for provision of care for the special needs populations and for provision of medically necessary, specialty care through direct access to specialists. The Hoosier Healthwise managed care program uses the definition and reference for children with special health care needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

> **"***Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."*

In accordance with 42 CFR 438.208(c), the State's enrollment broker conducts a Health Needs Screening (HNS) to identify members with potential special health care needs. The HNS tool assigns children to one of the Living with Illness Measures (LWIM) screener health domains based on the National Committee for Quality Assurance (NCQA) study design. The scoring for the LWIM screener identifies a child as potentially having a special health care need in one of seven different health domains:

- Functional limitations only
- Dependency on devices only

- Service use or need only
- Functional limitations and a dependency on devices
- Functional limitations and a service use or need
- Dependency on devices and a service use or need
- Functional limitations, a dependency on devices and a service use or need

The MCO will receive the HNS results for subsequent assessment by an MCO health care professional and to facilitate care coordination. However, not all Hoosier Healthwise enrollees complete the HNS tool and individuals can complete the HNS tool with or without the assistance of the enrollment broker. The State requires the MCO to conduct a HNS for its members who have not received the HNS at the time of enrollment.

In accordance with 42 CFR 438.208(c)(2), the MCO must have a health care professional assess the member when the HNS identifies the member as potentially having a special health care need. When the assessment confirms the special health care need, the MCO must coordinate the member's health care services with the member's PMP's plan of care. The MCO must offer continued coordinated care services to any special health care needs members transferring into the MCO's membership from another MCO. For example, MCO activities supporting special health care needs populations must include, but are not limited to:

- Conducting the initial HNS to identify members who may have special needs
- Scoring the HNS results
- Distributing findings from HNS to the State's enrollment broker, PMPs and other appropriate parties in accordance with State and Federal confidentiality regulations
- Conducting an HNS to confirm the member's special needs
- Coordinating care through a Special Needs Unit or comparable program services in accordance with the member's care plan
- Analyzing, tracking and reporting to OMPP the issues related to children with special health care needs, including grievance and appeals data
- Participating in clinical studies of special health care needs as directed by the Hoosier Healthwise Quality Improvement Committee

Multiple State agencies, including Medicaid, are considering use of the child and Adolescent Needs and Strength (CANS) assessment process to prospectively or retrospectively assess the needs and strengths of children and adolescents and support an outcomes-based quality management process. The results of CANS inform the child's treatment plan, provide level of care decision support, serve as an outcome measurement, facilitate communication between agencies and determine risk-adjusted funding. Several pilot programs in child-service systems in Indiana have already implemented CANS. Once the State finalizes the CANS tool, MCOs will be required to

adopt the assessment tool. Several of the MCOs are already participating in training to be "super users" of the CANS tool.

External Quality Review

An independent External Quality Review Organization (EQRO) will annually evaluate the Federal and State regulatory requirements and performance standards as they apply to MCOs in accordance with 42 CFR 438 Subpart E. Using definitions in 42 CFR 438.320, the EQR report will include an assessment of the services covered under each MCO contract for:

- Timeliness
- Outcomes
- Accessibility

Indiana OMPP currently contracts for an External Quality Review report. The Quality Strategy Committee and OMPP thoroughly review this report and assess the extent to which findings and recommendations put forth in the EQR are pertinent to the development and modification of the Quality Strategy. The State's monitoring contractor, Navigant Consulting, Inc. (NCI), produces several reports that are incorporated into the EQR report:

- An annual report that summarizes and analyzes the results of the MCOs' HEDIS results. The HEDIS report trends results by year for each of the MCOs, and compares the rates for Indiana's MCOs to national HEDIS Medicaid benchmark data produced by the National Committee for Quality Assurance (NCQA). The report includes NCI's recommendations for quality improvement initiatives.

- An annual summary of results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a national survey of Medicaid health plan consumer satisfaction. This report also trends survey results by year and by MCO, with recommendations for quality improvement initiatives.

- Quarterly performance monitoring reports. The MCOs report financial and service performance data on a quarterly basis, and NCI trends data by MCO, and identifies both strengths and risk areas requiring OMPP follow-up.

In the context of its review of all other EQR-required data, the EQRO reviews all of these reports, and provides additional analysis and recommendations to OMPP. The Quality Strategy Committee relies on the EQR report to assist them in making recommendations to OMPP regarding the development and modification of OMPP's Quality Strategy.

Clinical Standards and Guidelines

Contract language requires the MCOs to develop or adopt clinical practice guidelines that are evidence-based, consistent with national best practices and pertinent to the needs and characteristics of Hoosier Healthwise members. The MCOs must demonstrate that they have developed or adopted these guidelines in consultation with community providers and other health care professionals. The OMPP requires the MCOs to have policies and procedures describing how they review and update the clinical practice guidelines at least annually. The MCOs must also describe the process they use to identify the need for new clinical practice guidelines and must provide a plan for distributing practice guidelines to their contracted providers and monitoring provider compliance with the guidelines. Effective with the implementation of the 2007 contracts, MCOs must develop and disseminate provider profiles informing providers of how their practice patterns compare to those of their peers. The EQR review assesses compliance with 42 CFR 438.236 as it relates to the development and dissemination of clinical practice guidelines.

While the State does not require the MCOs to strictly follow any specific clinical practice guidelines, the OMPP has developed and promotes practice guidelines in the following areas:

- Guidelines for prenatal care, neonatal care, and well-child (EPSDT) visits based on HEDIS and HEDIS-like measures
- Integration between primary care and behavioral health based on data provided by MCOs for specific measures including coordination of care
- Behavioral health measures including acute and continuation phase therapies for depression and ADHD based on HEDIS measures
- Behavioral health post-hospitalization visit for seven and thirty day measures based on HEDIS measures
- Prevention visits based on standards recommended by the United States Preventive Services Task Force

Over the past year, the MCOs have convened a study group to compare and potentially consolidate clinical practice guidelines, as appropriate, across all MCOs. Because effective with the 2007 rollout of the Hoosier Healthwise program PMPs may now select to contract with more than one MCO, consolidating clinical practice guidelines to the extent possible would potentially support PMPs in delivering service in a more efficient manner, i.e., each MCO would have similar expectations for a PMP with regard to adherence to clinical practice guidelines.

Ultimately, this consolidation would provide a deliberate and focused message to providers regarding best practices for providing care to Hoosier Healthwise members, and would allow the MCOs to jointly provide outreach and training for those providers

whose practice patterns are not consistent with clinical practices chosen by consensus of the MCOs. For example, Indiana recently developed a database, the Children and Hoosiers Immunization Registry Program (CHIRP) for immunization and blood lead screening data. MCOs could jointly provide outreach and education to providers about the importance of providing timely immunizations and using this database to track member-specific data.

MCO Contract Compliance

The State places great emphasis on the delivery of quality health care to Hoosier Healthwise members. The Hoosier Healthwise MCO contract includes many provisions that promote the delivery of quality care. Performance monitoring and data analysis are critical components in assessing how well the MCO is maintaining and improving the quality of care delivered in the Hoosier Healthwise program. Table 1 below shows an overview of the mechanisms OMPP uses to monitor MCO contract compliance with critical performance standards. OMPP will use these same mechanisms to monitor progress toward meeting Quality Strategy goals and objectives.

Table 1: Overview of MCO Contract Compliance Monitoring Mechanisms

Monitoring Standards	Provider Survey	Member Survey	EQR	HEDIS	P4P	BCAP	MCO Reports	Dash-board Report	Onsite Visits to MCO	Contract Require-ments
	BA	A	A	A	A	A	Q	Q	M	V
Member Services		X	X	X			X	X	X	X
Provider Services	X		X	X			X	X	X	X
Network Access and Availability		X	X				X		X	X
Claims Processing	X		X				X	X	X	X
Member Grievances			X				X	X	X	X
Clinical Guidelines			X				X		X	X
Financial Performance/ Solvency			X				X	X	X	X
Quality Management	X	X	X	X	X	X	X		X	X
Behavioral Health			X	X			X	X	X	X

Key: BA=Bi-Annual, A=Annual, Q=Quarterly, M=Monthly, V=Varies

OMPP contracts with a monitoring contractor to assist OMPP in monitoring MCO performance within the Hoosier Healthwise program. The monitoring contractor works closely with the Medicaid Managed Care Manager and the Policy Analysts at OMPP to provide oversight of the MCOs. Each Policy Analyst has responsibility to monitor one of the MCOs that contract with the State. The Policy Analyst reviews MCO performance data on a monthly, quarterly, annual and ad-hoc basis and conducts monthly on-site visits to the MCO. The monitoring contractor provides technical assistance related to monitoring the MCOs' performance.

Contract Requirements and Monitoring Mechanisms

OMPP requires each MCO to submit performance reports on a regular basis, and uses these reports to monitor the MCO's performance and clinical outcomes against targets, standards and benchmarks. The State uses various performance targets, industry standards, national benchmarks and Hoosier Healthwise-specific standards.

In addition to the reports that the MCO regularly submits, OMPP monitors additional contract requirements that relate to the Quality Strategy goals and objectives, but are not formally reported as part of the data submission requirements. The Policy Analysts monitor these requirements during monthly onsite visits to the MCOs.

Dashboard Report

The monitoring contractor produces a quarterly "Dashboard Report" that trends and summarizes performance across MCOs for 22 financial and non-financial reporting requirements that are the most significant indicators of MCO performance. The OMPP Policy Analysts use the dashboard to guide follow-up monitoring activities and monthly onsite visits. See Appendix G for a sample of the Dashboard Report.

MCO Onsite Visits

Every month, OMPP Policy Analysts perform onsite visits to the MCOs. The agenda for the onsite visits changes monthly. During the onsite, the Policy Analyst reviews adherence to contract requirements, MCO performance results and areas of concern identified by OMPP.

Healthcare Effectiveness Data and Information Set (HEDIS)

OMPP began requiring Hoosier Healthwise health plans to collect data for selected HEDIS measures in 2001 to monitor and evaluate the delivery of health care services. Since that time, OMPP has continued to use HEDIS rates to:

1. Monitor MCO performance
2. Help identify potential opportunities for quality improvement activities
3. Demonstrate a commitment to quality improvement by publicly reporting selected Hoosier Healthwise program HEDIS rates

OMPP required MCOs to report 26 HEDIS measures for measurement year 2006. Several of these measures will be used to evaluate progress towards quality strategy goals and objectives. OMPP set target rates for selected HEDIS measures, which reflect the State's performance goals for the Hoosier Healthwise program. OMPP set these rates with recognition of the health plans' length of time serving the Hoosier Healthwise population, the challenges specific to Indiana, the health plans' experience reporting HEDIS rates and National Committee for Quality Assurance (NCQA) Medicaid percentiles. See Appendix B for a list of OMPP–required HEDIS measures and related performance targets.

Each year, OMPP's monitoring contractor prepares a report that summarizes the MCOs' HEDIS data and compares each MCO's results to results for the other MCOs, each MCO's previous years' rates, NCQA Medicaid percentiles, OMPP performance targets and the weighted average of the MCOs' rates. OMPP's monitoring contractor uses this data to prepare a public report that is posted on OMPP's website.

The HEDIS results have been and continue to be a critical data set, and OMPP's quality improvement process relies heavily on these data. OMPP requires each of the MCOs to develop a Quality Improvement Work Plan, the basis of which is HEDIS results and other data captured by the MCO. OMPP reviews and approves each MCO's workplan, and OMPP's Policy Analysts review the workplan throughout the year to determine if the MCO is following through on its commitment to quality improvement activities.

The Hoosier Healthwise Quality Strategy Committee reviews trends in HEDIS data and current year rates, and uses these data to inform their decisions about developing the Quality Strategy and designing and implementing quality improvement initiatives.

Pay-for-Performance

Beginning in January 2007, OMPP requires MCOs to participate in a Pay-for-Performance program that focuses on financially rewarding MCOs' efforts to improve quality and outcomes for Hoosier Healthwise members. The initiation of this program emphasizes OMPP's commitment to quality, and reflects OMPP's efforts to publicly recognize those MCOs providing exceptional quality of care. One of the Pay-for-Performance measures, Frequency of Ongoing Prenatal Care, relates to the Quality Strategy goals and objectives.

OMPP has identified priority areas for performance improvement through pay-for-performance based on important health indicators for the Hoosier Healthwise population that have associated, easily measurable health-promoting behavior over which the MCO has control.

OMPP will measure Frequency of Ongoing Prenatal Care during calendar year 2007 for purposes of determining any performance bonus to be paid in 2008. See Appendix D for a full summary of the Pay-for-Performance measures and associated targets.

<u>Performance Measures for the Quality Strategy Goals and Objectives</u>

Listed below are the performance measures, the data source, baseline data (where available) and the related performance targets that will be used to monitor progress in meeting the Quality Strategy objectives. For the goal of improving neonatal outcomes, OMPP is coordinating with ISDH to develop a neonatal outcomes study to measure performance on the Quality Strategy goals. OMPP will combine ISDH birth certificate

data with Medicaid data to identify the birth outcomes of Medicaid managed care members.

Performance Measure	Data Source	Baseline	Target
Goal: Improve Neonatal Outcomes			
Smoking rates during pregnancy	Combined birth certificate and Medicaid	TBD	Reduce by 5 percent
Low and very low birthweight	Combined birth certificate and Medicaid	TBD	Reduce by 5 percent and 5 percent
Pre-term deliveries	Combined birth certificate and Medicaid	TBD	Reduce by 5 percent
Prenatal/Postpartum Visit	HEDIS-like measure; Combined birth certificate and Medicaid	TBD	Increase by 5 percent

Health Information Technology

One component of the new Hoosier Healthwise contract with the MCOs effective January 1, 2007 is an enhanced use of Health Information Technology (HIT). The State recognizes that the use of HIT has the potential to improve the quality and efficiency of health care delivery in numerous ways. Digitizing and sharing health care data can reduce medical errors, increase efficiency, decrease duplicative or unnecessary services and reduce fraud and abuse. Additionally, HIT initiatives are important in improving the data quality necessary for public health research, evidenced-based decision-making, population health management and reduction of manual, labor-intensive monitoring and oversight.

Indiana recently submitted an amendment to its State Plan to enhance the delivery of child health through the Indiana Health Information Exchange (IHIE), a collaboration of Indiana health care institutions. The collaborative was formed for the purpose of using information technology and shared clinical information to improve the quality, safety and efficiency of health care to children in Medicaid and SCHIP.

The State strongly encourages the MCOs to develop, implement and participate in HIT and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in Indiana. In their proposal submissions for the 2007-2008 Hoosier Healthwise contract, each of the MCOs was required to propose how it would expand and enhance its use of HIT. The following are some examples of types of HIT initiatives that the MCOs proposed and are currently pursuing in their responses:

- Electronic Prescribing (e-prescribing), Electronic Medical Records (EMR), Inpatient Computerized Physician Order Entry (CPOE)
- Health Information Networks

- Benchmarking and Provider Profiling
- Telemedicine
- Data Registries

SECTION III. IMPROVEMENT

This section describes how, based on assessment activities, Indiana will attempt to improve quality of care, and specifically, what processes and tools OMPP will use to improve performance in meeting the Quality Strategy's objectives. OMPP determines interventions for quality improvement based on review and analysis of baseline data, results of quality improvement activities and ongoing assessment of members' health care needs. The following is a description of the process OMPP will use, along with a brief description of the various program components.

Implementing and Maintaining a Robust Quality Improvement Framework and Quality Strategy

OMPP's new enhanced quality framework, including the Quality Strategy Committee, will help support a strong, iterative quality improvement process and provide OMPP with the resources to implement quality improvement initiatives and monitor performance against quality strategy goals and objectives. Because the MCOs are critical representatives on all of the quality-related committees, the partnership between OMPP and the MCOs will be strengthened, enabling OMPP to work more effectively with the MCOs to realize the common goals of ensuring access, improving quality and working together efficiently.

Collecting and Analyzing Baseline Data, especially for Behavioral Health and Targeted Performance Measures

The Quality Strategy Committee will assist OMPP in analyzing HEDIS, CAHPS and utilization data. In addition, the Behavioral Health Workgroup helped to create new behavioral health performance measures and will serve a critical new role in analyzing behavioral health data and advising OMPP regarding behavioral health clinical standards and performance initiatives.

Pay-for-Performance

The Quality Strategy Committee will monitor results for the three priority areas for measurement year 2007. The Committee is considering making a recommendation to OMPP that MCOs would provide data on a more frequent, ongoing basis to better assist the Quality Strategy Committee in designing quality improvement initiatives in these critical areas throughout 2007 and 2008.

Mandating and Monitoring HEDIS and CAHPS Results
OMPP will continue to mandate MCO reporting of HEDIS and CAHPS results, and will work with the Quality Strategy Committee to monitor these results and use them to inform the design of quality improvement initiatives.

Conducting Provider Surveys
The Quality Strategy Committee recommends that OMPP continue to conduct provider surveys, at least bi-annually or in conjunction with major program modifications, and use the results of these surveys to provide feedback into the development of quality improvement initiatives.

Conducting Statewide Focus Studies
Over the past few years, OMPP has collected a wealth of information regarding MCO performance, network composition and the characteristics of the Hoosier Healthwise population. The timing is right for OMPP to sponsor one or more statewide focus studies that would enable the State and the MCOs to pool resources and focus on one or two priority areas with the common goal of improving outcomes in these areas.

Monitoring MCO Quality Improvement Initiatives
OMPP continues to monitor each MCO's Quality Improvement Workplan and its corresponding quality improvement initiatives. Many if not most of the quality improvement initiatives implemented by the MCOs will provide the impetus for statewide quality improvement activities.

Consumer and Provider Participation in Work Groups (especially CMHCs and other Behavioral Health Providers)
Consumers, providers and other stakeholders provide valuable feedback regarding the needs of members and providers, and how well OMPP and the MCOs are working together to meet those needs.

Educating Providers and Members
Consistent with the goal of the Quality Strategy to improve provider compliance with clinical practice guidelines, and in an effort to support quality improvement initiatives, OMPP and the MCOs have historically collaborated to help educate providers and consumers about evidence-based clinical practices (providers) and healthy lifestyle choices (members).

Cross Agency Collaboration, especially with ISDH, DMHA and OMPP
Representatives of DMHA and ISDH currently participate in the Quality Strategy Committee and workgroups. As a result of this participation, and the participation of MBHO representatives and behavioral health providers, the behavioral health workgroups have been successful in bringing behavioral health stakeholders together

across the table and addressing common concerns and issues in a deliberate and expedited manner. Additionally, OMPP is working with ISDH and other resources, such as the Indiana Quitline, on neonatal outcomes measures. OMPP plans to build on this collaborative model and involve other agency representatives to help drive additional quality improvement initiatives.

Using Feedback from the EQR Process

The EQR report provides a valuable source of information for developing quality improvement initiatives. For example, the most recent EQR report indicated some opportunities for improvement in the area of prenatal care. The State's managed care Pay-for-Performance program will focus on this area, rewarding MCOs for exceptional performance in 2008 based on 2007 performance.

Intermediate Sanctions and Corrective Action Plans

The premise behind the quality improvement process is one of *continuous* quality improvement. OMPP strongly believes in working with its MCOs in a proactive manner to improve the quality of care provided by Hoosier Healthwise members. While intermediate sanctions and corrective action plans are sometimes necessary, OMPP will use these tools to help drive quality improvement only when other strategies and tools have been considered and have not been effective. Sanctions are outlined in the MCO contract, and meet the Federal requirements of 43CFR Subpart I and the Indiana State requirements for sanctions and terminations. See Appendix E for a list of these sanctions.

SECTION IV. REVIEW OF THE QUALITY STRATEGY

The Quality Strategy Committee, on behalf of OMPP, has solicited substantial feedback regarding the proposed Quality Strategy. Not only has the Committee reviewed historical and current HEDIS, CAHPS and utilization data, but the Committee has received feedback from OMPP staff; representatives of the MCOs and MBHOs; providers (especially behavioral health providers and the Community Mental Health Centers); members of academia; Indiana's monitoring contractor Navigant Consulting, an international healthcare consulting firm; *OPENMINDS*, a national behavioral health consulting firm.

The Quality Strategy Committee initially reviewed and approved the draft of the Hoosier Healthwise Quality Strategy at a quarterly meeting on February 21, 2007. Subsequent to that meeting, OMPP representatives presented the draft Quality Strategy to CMS for its review and feedback in mid-March, 2007. Based on feedback from CMS and the various quality workgroups that have met throughout the first two quarters of 2007, the Quality Strategy Committee updated the Quality Strategy and is preparing to post it to the Hoosier Healthwise website for public comment. The Quality Strategy Committee will then incorporate public comment and "finalize" the Quality Strategy, submit it to CMS and continue the process that they have already begun of implementing the Strategy.

The Quality Strategy Committee will also develop a formal workplan with interim and strategic goals and objectives, potential barriers/challenges, accountabilities, and timelines, and will use this workplan to monitor compliance with the Quality Strategy.

The Quality Strategy Committee will present updates to OMPP and at public meetings on the progress that the Hoosier Healthwise program is making on implementing the Strategy. OMPP will provide an updated strategy to CMS only if significant changes are made. As appropriate, this update will document challenges and successes that result in changes to the strategy, including interim performance results for each objective.

SECTION V. ACHIEVEMENTS AND OPPORTUNITIES

This Section describes various quality improvement initiatives that OMPP and the MCOs have engaged in over the past few years, and discusses Indiana's progress in meeting objectives related to those initiatives and the Quality Strategy's goals and objectives. The MCOs and OMPP collaborated on a number of these projects, and in addition, the MCOs developed and implemented their own health plan-specific activities. Several of these projects were initiated during the 2000-2005 time period, and are continuing projects that, based on recommendations from the Quality Strategy Committee, OMPP and the MCOs will modify or enhance in 2007.

Achievements

HEDIS Results

Since 2002, when two of the current Hoosier Healthwise MCOs first began reporting HEDIS rates, the MCOs have made substantial rate improvements for many of the HEDIS measures. In addition to implementing a number of quality improvement initiatives that positively impacted on each MCO's performance, the MCOs also became more knowledgeable about using the HEDIS Technical Specifications to collect and report HEDIS data, resulting in substantial improvements in several rates and more accurate reporting that reflects true performance. In addition, OMPP and other State of Indiana governmental agencies collaborated on several of these quality improvement initiatives, and the MCOs – and most importantly, their members – benefited from these collaborations. The following descriptions and corresponding graphs highlight several of these improvements and upward performance trends of the Hoosier Healthwise MCOs as they relate to the Quality Strategy goals and objectives.

<u>Prenatal and Postpartum Care</u>

Although the Hoosier Healthwise weighted averages for timely prenatal and postpartum visits have improved since the time the MCOs began reporting these rates for measurement year 2002, the rates for *Postpartum Visit* did not meet the OMPP target, and are only slightly above the median rates for Medicaid MCOs reporting nationally. However, the rate for *Timely Prenatal Visit* improved from 68 percent in measurement year 2002, to 90 percent in measurement year 2005; the comparable NCQA HEDIS median rate for this cohort was 81.5 percent.

Figure 6: Prenatal and Postpartum Care - Prenatal Visit

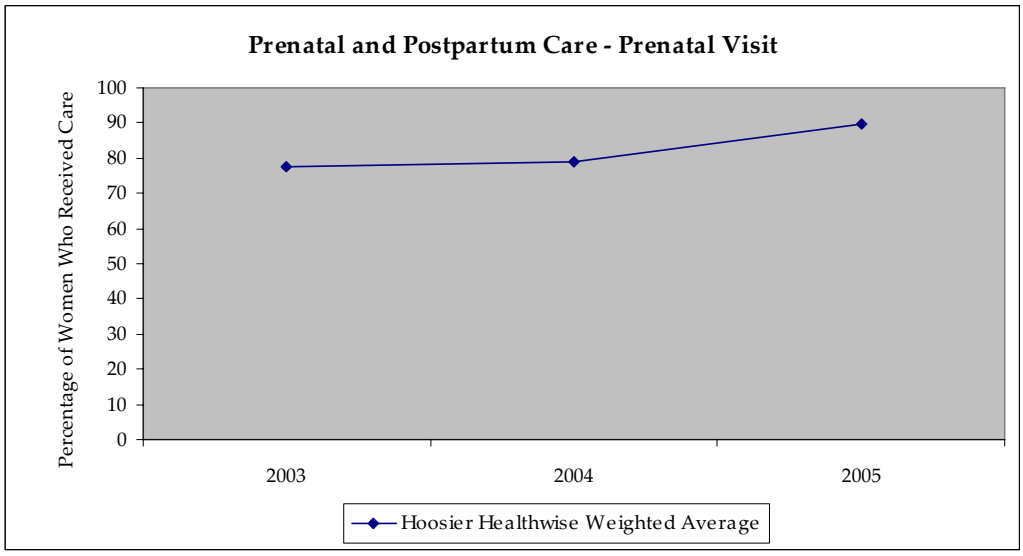
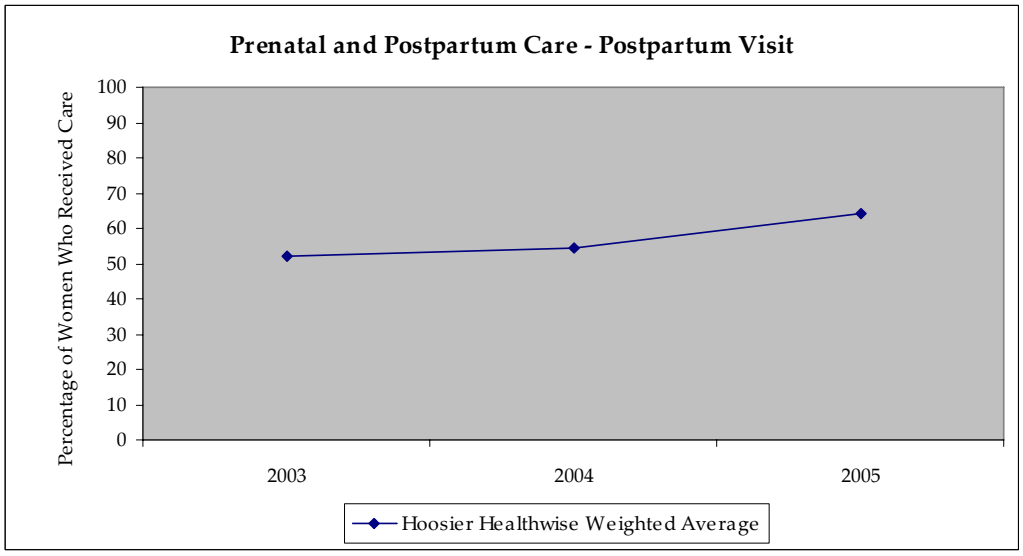


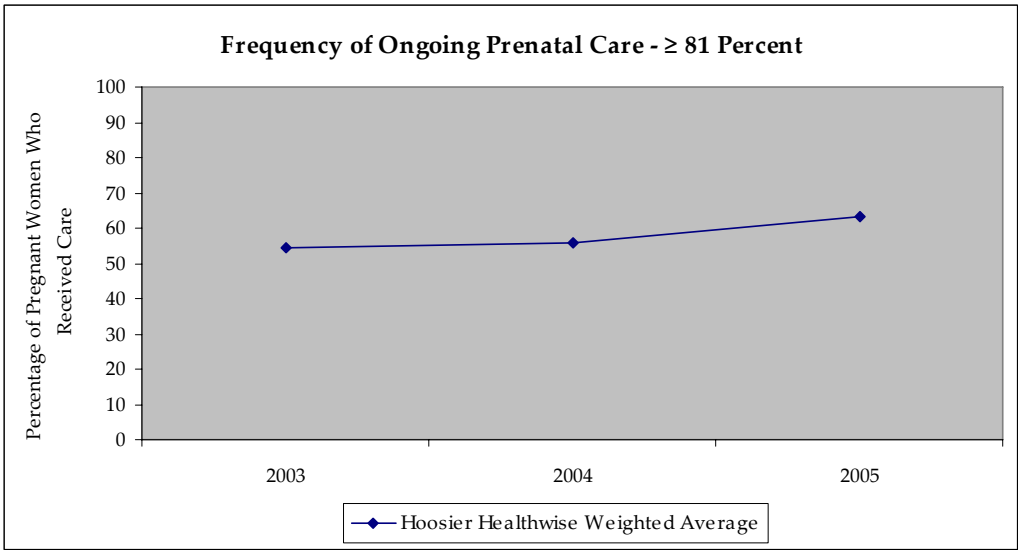
Figure 7: Prenatal and Postpartum Care - Postpartum Visit



Frequency of Prenatal Care

All MCOs posted improvement in 2005 over 2004 rates for members receiving at least 81 percent of expected prenatal care visits. Although the weighted average of 63 percent did not meet the OMPP target of 66 percent, it did exceed the NCQA median rate of 57 percent. This measure is a Pay-for-Performance measure for measurement year 2007.

Figure 8: Frequency of Ongoing Prenatal Care - ≥ 81 Percent



Opportunities

The Quality Strategy Committee has identified several areas of opportunity to measure, monitor and improve performance on quality measures. Since behavioral health is newly carved into the responsibility of Hoosier Healthwise MCOs, OMPP will monitor this area closely over measurement year 2007.

Behavioral Health Outcomes

The State will use measurement year 2007 to design appropriate indicators of behavioral health quality, gather baseline data and discuss appropriate quality improvement activities. The Behavioral Health Workgroup has discussed several measures including behavioral health emergency room use, follow-up after inpatient admission, prescription drug utilization and inpatient readmission rates. The MCOs will report utilization for behavioral health services, which OMPP will compare to the baseline data to identify changes in utilization patterns that may signal access issues.

The Behavioral Health Workgroup has also discussed primary and behavioral health integration as one indicator of quality; however, integration is difficult to measure and quantify. The Workgroup has already worked to facilitate the data sharing process. The Workgroup has drafted recommendations to OMPP regarding data sharing requirements between physical and behavioral health providers. The Workgroup

proposed a two-tiered approach to data sharing. Members who meet OMPP's contract criteria for "high risk," i.e., they have had an inpatient hospitalization or are at risk for an inpatient hospitalization are in Tier 1. The Workgroup further recommends that all of these high risk members receive case management services from the MBHO. For these members, behavioral health providers would need to communicate a summary of the member's initial diagnostic/assessment session, primary and secondary diagnoses, medications prescribed, changes in levels of care (e.g., inpatient admission or discharge, moving from an inpatient hospitalization to a partial hospital program, etc.) and other relevant information.

Members who receive behavioral health services but who do not meet the criteria for Tier 1 members are in Tier 2. The Workgroup recommended that the behavioral health providers would follow somewhat less rigorous standards for reporting on these members, but would still report key member-specific information needed by the PMP and other providers.

OMPP is developing metrics to assess the effectiveness of the MCOs' efforts to effectively integrate behavioral and physical health, for example, monitoring the number of summary reports submitted to PMPs regarding their members receiving behavioral health services, monitoring of the annual CAHPS data, and assessing the number of high-risk members in intensive case management.

Conclusion

The Quality Strategy Committee presented and discussed drafts of the Quality Strategy during public meetings on February 21, May 16 and August 15, 2007. In addition to the Quality Strategy Committee, Neonatal Outcomes Workgroup and Behavioral Health Workgroup members, meeting attendees included the Indiana State Medicaid Director, the CEOs and Medical Directors of the MCOs, as well as representatives from OMPP, DMHA, ISDH, MBHOs and provider organizations. These meetings established a collaborative and participative tone for Quality Strategy and quality improvement activities going forward.

The Quality Strategy Committee approved the draft Quality Strategy and supported the goals and objectives outlined in the Quality Strategy. Many participants were excited about the willingness of the various stakeholders to participate in the Quality Strategy process and expressed an eagerness to start the work of implementation.

SECTION VI. APPENDICES

Appendix A: Medicaid, SCHIP and Hoosier Healthwise Eligibility

Appendix B: HEDIS Results, OMPP Targets and NCQA Benchmarks, Measurement Years 2002-2005

Appendix C: Summary Results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Measurement Years 2003-2005, Adults and Children

Appendix D: Pay-for-Performance Measures and Performance Targets, 2007-2008

Appendix E: OMPP Performance Reporting Requirements, 2007-2008

Appendix F: Sanctions

Appendix G: Sample Dashboard Report